DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-022

2. STATE: Vermont

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 195,313
b. FFY 2004 $ 234,375

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See attached

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See attached

10. SUBJECT OF AMENDMENT:
Methods, Standards, and Principles for Establishing Medicaid Payment Rates for Long-Term Care facilities

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary of Administration 12/23/02

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
M. Jane Kitchel

14. TITLE:
Secretary, Agency of Human Services

15. DATE SUBMITTED:

16. RETURN TO:
Roxanne Doty
VT Dept. of PATH
103 South Main Street
Waterbury, VT 05671-1201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 10, 2003

18. DATE APPROVED: AUG 25 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: NOV - 1 2002

20. SIGNATURE OF REGIONAL OFFICIAL: Brown for Smith

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE OF VERMONT

AGENCY OF HUMAN SERVICES

DIVISION OF RATE SETTING

METHODS, STANDARDS AND PRINCIPLES FOR ESTABLISHING MEDICAID PAYMENT RATES FOR LONG-TERM CARE FACILITIES

November 1, 2002

IV. CASE-MIX REIMBURSEMENT STANDARDS

(a) Rates set under this plan are intended to provide incentives to control costs and Medicaid outlays, while promoting access to services and quality of care. This case-mix reimbursement system takes into account the fact that some residents are more costly to care for than others.

(b) Case-mix rates shall be adjusted based on resident assessments made pursuant to 42 C.F.R. §483.20, according to the resources utilized to care for the residents of each facility. (See Addendum A §5.1.) Case-mix adjustments may be limited to Medicaid residents only. Thus the system requires:

(1) the assessment of residents on a form prescribed by the Director of the Division of Licensing and Protection,
(2) a means to classify residents into groups which are similar in costs, known as 1992 RUGS-III (44 group version); and
(3) a weighting system which quantifies the relative costliness of caring for different classes of residents to determine the average case-mix score for each facility. (See Addendum A §7.2)

(c) Per diem rates shall be prospectively determined for the rate year, based on the allowable operating costs of a facility in a Base Year plus property and related and ancillary costs from the most recently settled cost report. (See Addendum A §7.8.)

(d) A Base Year shall be a calendar year, January through December. The Director shall determine the frequency of rebasing and shall select the Base Year. However, rebasing for Nursing Care costs shall occur no less frequently than once every three years and for other costs no less frequently than once every four years, unless the Secretary, on the advice of the Director, certifies to the General Assembly that rebasing is unnecessary, or

a modification of this schedule is authorized by statute. (See Addendum A §5.6.)

(e) In the case-mix system of reimbursement, allowable costs are grouped into cost categories. The accounts to be used for each cost category shall be prescribed by the Director. (See Addendum B §6.) The Base Year costs shall be grouped into the following cost categories: Nursing Care Costs, Resident Care Costs, Indirect Costs, Director of Nursing, Property and Related, and Ancillaries. Nursing Care costs shall be adjusted quarterly for changes in each facility's case-mix score. (See Addendum A §9.7.)

(f) The following cost limits shall be applied:

(1) Nursing Care component - median cost for all facilities plus 15 percent.
(2) Resident Care component - median cost for all facilities plus 5 percent.
(3) Indirect component - median cost for all privately owned nursing facilities, except for special hospital-based facilities for which the limit is 137 percent of the median. (See Addendum A §§7.2-7.4)

(g) The Division shall by rule establish a method for determining the appropriated number of resident days to be used in calculating per diem rates and shall prescribe a minimum occupancy level (not lower than 90 percent of the certified beds in each facility) to be used for the purpose of calculating per diem costs and rates, which may be waived by rule for certain cost categories and certain types of facilities, including, but not limited to, those with 20 or fewer beds or terminating facilities. (See Addendum A §5.7.)

(h) The Division shall by rule prescribe methods to be used for adjusting costs for projected economic conditions during the rate period. The Division may use inflation factors based on the DRI-NHMB and/or the NECPI or similar indexes. Different inflation factors are

Allowable Costs or Expenses: costs or expenses that are recognized as reasonable and related to resident care in accordance with this plan and the Division's rules.

Ancillary Services: therapy services and therapy supplies, including oxygen, whether or not separate charges are customarily made. Other medical items or services identifiable to a specific resident furnished at the direction of a physician and for which charges are customarily made in addition to the per diem charge.

Base Year: a calendar year for which the allowable costs are the basis for the case-mix prospective per diem rate.

Case-Mix Weight: a relative evaluation of the nursing resources used in the care of a given class of residents.

Centers for Medicare and Medicaid Services(CMS) (formerly called the Health Care Financing Administration (HCFA)): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Cost Report: a report prepared by a provider on forms prescribed by the Division.

Director: the Director, Division of Rate Setting, Agency of Human Services.

Division: the Division of Rate Setting, Agency of Human Services.

DRI: Data Resources Institute Incorporated's *Health Care Costs, as published by McGraw-Hill,* including national forecasts of hospital, nursing home, and home health agency market baskets and regional forecasts of CPI (All Urban) for food and commercial power and CPIU-All Items.

Facility or nursing facility: a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Vermont.

FASB: Financial Accounting Standards Board.

Generally Accepted Accounting Principles (GAAP): those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

Generally Accepted Auditing Standards (GAAS): the auditing standards that are most widely recognized in the public accounting profession.

Incremental Cost: the added cost incurred in alternative choices.

Inflation Factor: a factor that takes into account the actual or projected rate of inflation or deflation as expressed in indicators such as the New England Consumer Price Index.

Interim Rate: a prospective Case-Mix rate paid to nursing facilities on a temporary basis.

New England Consumer Price Index (NECPI-U): the consumer price index for all urban consumers as forecasted by DRI McGraw-Hill.

OBRA 1987: the Omnibus Budget Reconciliation Act of 1987.

Occupancy Level: the number of paid days, including hold days, as a percentage of the licensed bed capacity.

Per Diem Cost: the cost for one day of resident care.

Prospective Case-Mix Reimbursement System: a method of paying health care providers rates that are established in

advance. These rates take into account the fact that some residents are more costly to care for than others.

Provider Reimbursement Manual, CMS -15: a manual published by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, used by the Medicare Program to determine allowable costs.

Rate year: the State's fiscal year ending June 30.

Resident Day: the care of one resident for one day of services. The day of admission is counted as one day of care, but the day of discharge or death is not. A paid hold day is counted as a resident day.

RUGS-III: A systematic classification of residents in nursing facilities based upon a broad study of nursing care time required by groups of residents exhibiting similar needs.

Rules: as used in this state plan Attachment 4.19D, refers to Addendum A.

Secretary: the Secretary of the Agency of Human Services.

State nursing facilities: facilities owned and/or operated by the State of Vermont.

Swing-Bed: a hospital bed used to provide nursing facility services.